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AUTHOR Wisocki, Patricia A.
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ABSTRACT

Given the facilitating conditions and the characteristic qualities of worry, the elderly seem to be particularly susceptible to the experience of worry. The Worry Scale was developed in response to the concerns expressed about life events measures and as an attempt to address the needs of elderly people directly. Older adults (N=94) from 11 senior center programs and meal-sites in New England completed the Worry Scale, a Background Information Questionnaire, a variation of the Multiple Affect Adjective Checklist, and the Symptoms Checklist (SCL-90). The results indicated that respondents were generally healthy and worry free. Their primary worries included concern over sensory and motor losses, failing memory, illness or accident occurring to close family members, relocation, loss of independence, getting depressed, and loss of family and friends. There were no significant sex differences in responses, nor differentiation by socioeconomic status or marital status on the Worry Scale. Only health worry scales correlated significantly with increased age. Total Worry Scale scores and each subscale score were significantly correlated with anxiety scale scores. Respondents who were high in worry scores were shown to be less healthy, more anxious, less vigorous, and less contented than were respondents who did not indicate a high worry scale. These data have implications for the ways the elderly cope with stressful items. (NB)

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Worry as a Phenomenon Relevant to the Elderly

Patricia A. Wisocki

University of Massachusetts

at Amherst

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Address requests for reprints to:

Dr. Patricia A. Wisocki

Psychology Department

University of Massachusetts

Amherst, MA 01003

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Abstract

In this paper the author explores the construct of worry as it pertains to the elderly. Given the facilitating conditions and the characteristic qualities of worry, the elderly seem to be particularly susceptible to the experience of worry. Data are presented from a study of 94 elderly who completed a variety of questionnaires dealing with worry, anxiety and demographic variables.

Results indicate that respondents were generally a healthy and worry free group of people. Their primary worries included concern over sensory and motor losses, failing memory, illness or accident occurring to close family members, relocation, loss of independence, getting depressed, and loss of family and friends. There were no significant sex differences in responses, nor differentiation by socio-economic status or marital status on the Worry Scale. Only health worry scales correlated significantly with increased age. Total Worry Scale scores and each subscale score were significantly correlated with anxiety scale scores. Respondents who were high in worry scores were shown to be less healthy, more anxious, less vigorous and contented than respondents who did not indicate a high worry scale. These data have implications for the ways elderly cope with stressful items.

Worry as a Phenomenon Relevant to the Elderly

Patricia A. Wisocki

University of Massachusetts at Amherst

Worry has been defined by Borkovec, Robinson, Pruzinsky, and DePree (1983) as "a chain of thoughts and images negatively affect-laden and relatively uncontrollable" (p. 10). In a later paper Borkovec (1984) defined worry as "the cognitive aspect of anxiety" and presented the stimulus conditions for worry as "proximally or distally fear-related events...representing anticipated future negative outcomes" (p. 1). According to Borkovec, the characteristics of worry include a predominantly future-orientation, habitual elicitation by a diffuse number of environmental events which may be relevant or irrelevant to the worry topic, a resemblance to fear in subjective aspects (i.e., feelings of anxiety, apprehension, insecurity, frustration) and somatic aspects (i.e., muscle tension, gastro-intestinal upset). Like fear, worry can incubate and in some cases it serves as a cognitive avoidance procedure to temporarily reduce fear. Worry has been associated with a pervasive and continuous negative emotional life. It has a disruptive effect on attention. It is most consistently induced by periods of inactivity and low environmental demand. Borkovec has speculated that fear of failure is at the center of the worrier's anxiety. Like other anxiety disorders, he maintains that the worry process is strongly associated with social evaluation, including specific fears of rejection, making mistakes, being criticized and others. Worry has been implicated strongly in the maintenance of insomnia (Borkovec, 1979), anxiety, depression, and

obsessive-compulsive behavior (Borkovec, Wilkinson, Folensbee, & Lerman, 1983).

The data which form the basis for these findings have been primarily derived from samples of college students. Until a recent study by Wisocki, Handen, and Morse (1986), there were no data on worry collected from elderly subjects. Yet it would seem that the elderly are a population particularly susceptible to the effects of worry. The facilitating conditions of frequent periods of inactivity and low environmental demand and typical of many elderly. Indeed, some of the characteristics most often associated with aging include behavioral slowing (Birren, Woods, & Williams, 1980), a dearth of reinforcers, apathy or a lack of interest in events. The elderly often seem fearful of making mistakes and express this fear in increased cautiousness (Botwinick, 1978). Attention deficits are commonly associated with the aging process. Investigators have proposed two explanations for this problem. Some investigators maintain that the elderly have difficulty separating relevant information from the irrelevant (Rabbitt, 1977; Schonfield, 1974). A different view was presented by Layton (1975) who reviewed the research on age differences in attention. Layton contends that aging is accompanied by a decrement in the ability to suppress irrelevant stimulation on both internal and external levels. In either case, there seems to be fertile ground for worry. And, if present, worry can further disrupt one's level of attention, causing additional problems for the aging organism. The elderly as a group complain frequently of insomnia, depression, and anxiety, all problems which are associated with the worry process. For instance, in one survey of healthy, community-dwelling

elderly, Karacon, Thornby, Anch, Holzer, Warheit, Schwab, and Williams (1976) found that 23% of respondents over 60 years of age reported frequent sleep problems. Other community surveys (e.g., Gaitz, 1977) have found that the majority of elderly respondents reported behaviors associated with depression, like pessimistic views of the future, appetite disturbances, sad mood, etc. The rates of clinical depression, however, are not that high. Most studies report a prevalence rate around 6% (e.g., Blazer & Williams, 1980). More general estimates of pathology are higher, according to various studies. Blazer (1980) estimated that 10%-40% of the elderly community population have mild to moderate psychiatric impairment. While Kay and Bergmann (1980) have put the number of neurotic disorders lower (4%-9%), Pfeifer (1977) concluded that approximately 15% of the elderly U.S. population suffer from some degree of psychopathology.

No one would be surprised, then, to find that the elderly experience a significant amount of worry. Objectively speaking, the elderly may rightly anticipate a number of chronic health problems (e.g., impaired mobility, sensory decline, diseases) and serious social changes (e.g., declines in income, loss of family members and friends), any or all of which may produce considerable stress to which the aging brain becomes less adaptable (Timaris, 1972).

Based on her clinical work with elderly clients, Fry (1986) has delineated several specific fears experienced by the elderly which relate to the daily problems of living and coping with physical hardships, loneliness, and personal suffering. The topics of these fears include sensory deprivation, especially hearing loss; mental decline and mental

illness; loneliness and segregation from society; crime and violence; physical illness and physical disability.

Given the climate, stress levels among the elderly should be high and their adaptability levels should be low since coping resources are said to diminish in old age. In fact, Pfeiffer (1977) has ventured the claim that most mental pathology in later life is due to the failure of the older person to cope with stress brought on by conditions of aging. When investigators have examined specific sources of potential stress for the elderly, however, such as relocation, retirement, or bereavement, such equivocal evidence has been presented that conclusions are impossible to draw. Kasl and Rosenfield (1980) point out that the impact of relocation on the psychological health of the elderly is not significant. Retirement, an identified stressor by some (e.g., Atchley, 1976; Fox, 1977) has not been correlated with high stress rates. A United States Department of Health, Education and Welfare Report on aging (1979) cited an alarming increase in the death rates among elderly due to personal loss of loved ones, but no empirical evidence supports this statement conclusively.

While there is a general paucity of research on stress and the elderly, the studies available have primarily focused on a life-events approach. According to the data derived from these studies, the elderly experience fewer life events in general than younger populations (Chiriboga & Dean, 1978; Masuda & Holmes, 1978); and report less disruption from various life events than the younger subjects do (Horowitz, Schaefer, & Cooney, 1974).

Renner and Birren (1977) have suggested that the elderly experience fewer stressors than younger populations and are more psychologically

prepared for those they do face. The results of some studies lend support for such a claim. For example, Sands and Parker (1979-80) found no difference in the amount of stress reported by subjects in the age groups of 18-24, 30-40, and 65-86 when they all completed the Holmes-Rahe Life Events Scale (Holmes & Rahe, 1967) and the Amster-Krauss Scale (Amster & Krauss, 1974), which contains items especially relevant to older populations, such as failing eyesight, the possibility of institutionalization, loss of one's driver's license and so forth. In toto, the responses of the younger subjects were the same as those of the older subjects. There were some differences in specific items, however. The elderly subjects reported more stress connected with changes in social activities, feeling of slowing down, vacations, holidays, and anniversaries. They reported less stress connected with death-related events (e.g., death of a spouse, close friend, or family member) and changing to a different line of work.

Palmore, Cleveland, Nowlin, Ramm, and Siegler (1979) found that none of the specific life events often associated with aging need be a precipitation of illness in older people, although the probability increases that health declines if more than one such event is experienced in a particular time period. Similar findings were reported by Stilwell (1983) who analyzed life stress events scores with multiple regression techniques in which the dependent variable was daily life function. She found that the life events score was not by itself a significant predictor variable of negative consequences in these areas for elderly people. Only in interactions with age, sex and other variables were life events scores important in predicting adverse effects.

Lazarus and DeLongis (1983) have argued effectively that a life events approach to stress does not provide sufficient indication of the impact of stress on an individual's life. They mention these specific problems with the use of life events measures: a focus on dramatic events; an emphasis on change as the stimulus for anxiety; a failure to consider mediating processes, such as the personal significance of an event and the ways people use to cope; and a lack of items relevant to the elderly in general, making unwarranted any conclusion about a reduction in stress related to increased age.

The Worry Scale (Wisocki & Handen, 1983) was devised in response to the concerns expressed about life events measures and as an attempt to address the needs of elderly people directly. It is future-oriented and allows for personal evaluations of specific events. As Lowenthal and Chiriboga (1975) have determined, knowledge of how a person perceives stress contributes to the understanding of the relation of life events to adaptation. Worries are thought to be examples of the proximal issues described by DeLongis, Coyne, Dakof, Folkman, and Lazarus (1982) in that they represent matters of immediate concern to the person. Worries cause concern stretching into the future and thus are areas in which action by the person or by others might be of importance in improving life quality.

In a study comparing the worries of 51 community active elderly and 44 homebound elderly, Wisocki, Handen, and Morse (1986) found relatively few worries reported overall by both populations. Health concerns predominated for both groups. The homebound elderly differed from the community-active elderly only on three specific worries having to do

with loss of mobility, the experience of serious illness or accident by a close family member, and the lack of ability to care for one's spouse. In this study they also substantiated the usefulness of the Worry Scale as a measure of anxiety. The Worry Scale correlated significantly with various anxiety, depression and hostility scales for the homebound group. For the community active elderly only the anxiety scales correlated significantly with the Worry Scale. In examining relevant demographic variables the authors found that the Worry subscales of financial, health and social concerns were significantly correlated with financial status and health measures for both groups. Social support measures were significantly correlated with the social worries subscale for the homebound group only.

The purpose of the present study was to expand our knowledge of the worries of elderly men and women by enlarging the sample completing the Worry Scale, by focusing on healthy, active elderly and by comparing worries and non-worries on various measures.

Method

Subjects

A sample of 94 people were recruited from 11 different senior center programs and meal-sites throughout New England. They ranged in age from 60 to 90 with a mean age of 72. Sixty-nine percent of the sample was female. Fifty percent were widowed, 36% were married, and 11% were either single or divorced. Working class status was indicated for 55% of the group; white collar/professional for the remainder. Sixty-four percent of the respondents reported annual incomes under $10,000; 13.8% reported income in the $10,000-$20,000 range, and 12.8% said they currently earned between $20,000-$30,000. Prior to retirement 40.5% earned less than $10,000; 29.7% made between $10,000-$20,000; 14.9% made between $20,000-$30,000, 10.8% made between $30,000-$40,000; and 4.1% reported earning more than $50,000.

Respondents had been retired an average of 10 years, although some were still employed. Twenty-seven percent had completed 11 years or fewer of education; 36% had graduated from high school; 37% had continued their education beyond high school. Church membership was reported by 87% of the sample. Seventy-five percent reported their health status as excellent or good, and 82% reported no change in health status over the past six months.

Materials

Each subject was given the following set of questionnaires:
(1) Background Information Questionnaire which elicited demographic and personal data, including the number and frequency of social contacts, overall subjective judgment of health (poor, fair, [illegible]xcellent), and

the number of days in bed during the last year, and self-reported judgments about changes in health over the past six months. Each respondent also indicated any identified chronic conditions or problems from a list of 11 specific items and an open-ended "other" category. The total number of positive responses for these 12 items was used as the indicator of chronic illness. (2) A variation of the Multiple Affect Adjective Checklist (MAACL), developed by Zuckerman (1960) and scored according to methods reported by Nowlis (1965) who identified several factors including anxiety, aggression, vigor and elation within this 132-item adjective list. Factor subscales are scored by a tally of circled adjectives relevant to each factor. The anxiety score is comprised of the following items: afraid, fearful, frightened, hopeless, nervous, panicky, terrified, worrying. The aggression score is based on responses to the following adjectives: angry, annoyed, aggressive, contrary, cross, disagreeable, enraged, furious, hostile, incensed, indignant, mad, outraged, stormy, stubborn. The vigor scale is composed of the following: active, alive, energetic, enthusiastic, fine, fit, good, healthy, strong. The elation scale contains these adjectives: cheerful, enthusiastic, fine, glad, good, happy, joyful, pleased, satisfied. In addition, a contentment scale was derived from these items: agreeable, contented, cooperative, amiable, calm, peaceful, polite, thoughtful, understanding. This scale was not one identified by Nowlis. (3) The SCL-90 (Derogatis, Rickles, & Rock, 1976), a 90-item self-report symptom inventory on which respondents indicate how much the problem bothered them in the past 2 weeks on a 5-point scale (0 = extremely; 1 = quite a bit; 2 = moderately; 3 = a little bit; 4 = not at all). Three scales were utilized: anxiety,

hostility, and interpersonal sensitivity, derived according to the methods specified by Derogatis and Cleary (1972). (4) The Worry Scale (Wisocki & Handen, 1983), a 35-item questionnaire on which subjects are asked to indicate how much they worry about problems in the areas of finances, health and social conditions, according to a 5-point scale including never; rarely (1-2 times a month); sometimes (1-2 times per week); often (1-2 times per day); much of the time (more than two times per day). The Worry Scale is scored from zero to +4 in ascending order according to each response category. Subscale correlations with the total worry score, as well as correlations of individual items to the subscale totals were significant at the .001 level.

Procedure

The directors of eleven senior centers in New England agreed to participate in the study. The experimenters met with the members of the centers in a group, explained the study, and requested volunteers. Those who had agreed to participate were given the questionnaires in groups of 5-10. Experimenters were available throughout the testing to answer questions and to assist those who may have had visual or physical impairments. This assistance took the form of restating the questions.

Results

As in the previous study with community active and homebound elderly (Wisocki, Handen, & Morse, 1986), this sample of elderly reported few worries overall. Distributions on all subscales were positively skewed. Table 1 shows total worry scale scores, mean scores on the three component

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Insert Table 1 about here

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scales (financial, health and social worries), distributions for each item, and averages for women and men. The small differences in female and male scores are not significant (t Financial = .65, t Health = .25, t Social = -.36, t Total = -1.12, df = 73), although white collar/professionals reported slightly higher levels of worry on the three subscales. Marital status did not differentiate reported worries (F Financial = .807, F Health = .705, F Social = 2.037, F Total = 1.107, df = 3, 85). Only health worry scores were significantly correlated with increased age (r = .088, n = 86, p = .012).

Most and least frequent worries expressed by this population are shown in Table 2.

Insert Table 2 about here

Total Worry Scale score and each subscale score were significantly correlated with the anxiety scale scores derived from the SCL-90 and the MAACL. These and other correlations to SCL-90 and MAACL-derived scores are shown in Table 3.

Insert Table 3 about here

The respondents reporting the greatest worries (approximately 15% of the population) were compared on the indicators of anxiety and health.

They were significantly more anxious on both indicators of anxiety than the 85% less-worried respondents ($\bar{X}$ high MAACL = 225, t = 2.91, df = 12, p = .01; $\bar{X}$ high SCL-90 = 35.0, t = 2.97, p = .01). They also rated themselves as in poorer health ($\bar{X}$ high worry = 2.0, $\bar{X}$ = low worry = 2.9, t = 2.95, df = 94, p = .004), less vigorous ($\bar{X}$ high worry = 3.75, $\bar{X}$ low worry = 5.5, t = 2.30, df = 95, p = .04) and reported more chronic illness ($\bar{X}$ high worry = 4.2, $\bar{X}$ low worry = 1.75, t = 2.82, df = 95, p = 006). They did not differ from the less worried group in age ($\bar{X}$ high worry = 72.5 years; $\bar{X}$ low worry = 71.8 years), current or pre-retirement income (t = 1.0).

In order to examine further the correspondence between worry scales and other indicators, two subgroups were compared with the remaining respondents: those people who circled "worrying" on the MAACL (14% of the sample) were compared with those who had not. Those people who circled "secure" (57% of the sample) were compared with those who had not selected that adjective. Worrying people were less healthy (t = 2.71, p = .015) and more worried on all subscales (t total worry = 3.21, p = .002). They were more anxious as indicated by scores on both the MAACL-derived anxiety score (t = 2.36, p = .03). They also scored significantly lower on two additional MAACL-derived scales of vigor and contentment (t = 2.08, 2.11, p = .04, respectively, t elation = 1.93, p = .057) and they were less healthy as indicated by overall health ratings and number of chronic conditions reported (t = 3.88, 2.38, p = .003, .02 respectively). The limitations imposed by health did not differentiate the two groups. In contrast, the respondents circling "secure" manifested less financial worry (t = 2.57, p = .01). They indicated somewhat fewer social and

health-related worries also, but those differences were not significant. These "secure" people were significantly more vigorous, elated and contented than the remainder of the respondents (t = 3.43, 4.10, 4.41, p = .007; .000). The differences in anxiety on the two scales used were in the predicted direction, but they were not significant.

Discussion

This group of elderly indicated few anxieties or worries. Instead, they responded positively to the subscales for elation, vigor, and contentment. Indications of psychopathology revealed by the SCL-90 were minimal, although it is interesting to note that the percentage of worriers (14%) corresponds closely to the estimated percentage of elderly suffering from some degree of psychopathology in the general community (e.g., Pfeiffer, 1977). Those reporting fewest worries reported the least amount of anxiety.

Comparisons with an investigation by Romaniuk, McAuley, and Arling (1983) support the impression gained from these data that the sample is a rather healthy and unworried one. Romaniuk, McAuley, and Arling (1983) examined a sample representative of the older people of Virginia who were, in general, less educated, with lower incomes and lower health self-ratings and who manifested psychiatric disorders higher than those hinted at by SCL-90 findings in the present study. Twenty-three percent of the people in that study reported feeling worried very often, in comparison with the 14% in our sample. Like the findings in this study, Romaniuk et al (1983) also reported no significant sex differences on psychological disorders, but did not find indications that women exhibited or reported more worry than men.

Those worries which were expressed were consistent with the relatively robust characteristics of this sample. These elderly, for example, were not as worried about paying for the basic necessities of life as they were about making financial contributions to their children and enjoying recreational opportunities. They were worried about maintaining financial independence, a frequently observed influence on status of the elderly and on their relations with their children (e.g., Johnson & Burke, 1977).

The health-related items which provoked the most worry are also congruent with the wish to remain independent and able to care for oneself. These worries included concerns about sensory and motor losses, failing memory and decision-making abilities, serious illness or accident to spouse or close family members, the need to move into a nursing home or hospital, or be cared for by strangers. They are similar to ones identified by Chiriboga and Cutler (1980) as being most salient to the elderly. The strongest observed relationship among the health measures was that between chronic illnesses and health worries. The observation that health-related worries tend to increase among older respondents is realistic and expected, since older people do have more health problems than younger people.

The expressed social worries also indicated a fear of being a burden to loved ones, getting depressed, losing family and friends. A worry expressed by the population and identified in other surveys of older Americans (Lee, 1983) is that of victimization, here particularly that one's home may be broken into and vandalized. The older people also had some concerns about being unaided in time of need.

These are all legitimate worries, and serve to remind us of the

areas in which useful interventions might be considered. The results of this study are, of course, restricted to the sample of people responding to the questionnaires. This sample of elderly was generally healthy, active and in good financial straits. While they are not representative of the elderly at large, they are representative of a group rarely studied in gerontology. While the pattern of results for this sample was relatively consistent, in light of the relatively small r values, and the increased Type I error with multiple tests, the results should be viewed as provisional. It is also important to recognize that, like all self-report measures, there may be response bias. The elderly in this sample may have tried to paint a more positive picture of themselves than is accurate. Supplementary behavioral measures and reports from others acquainted with the respondents would help to establish the validity of the positive outlook they reported.

Similar studies are needed for other populations of elderly, including the poor, the disadvantaged, the nonwhite, and the troubled. It is especially important to study clinical samples of elderly who have presented problems of depression, anxiety, or fear.

Finding a relative absence of worry provokes a variety of speculations. There may be an age-related biochemical decline in cognitive functioning which somehow lessens the impact of a stimulus so that it does not elicit worry. There is no clear evidence, however, to support such a biological condition. It is more useful to consider the lack of worry as indicative of an effective coping strategy, allowing the elderly to adapt to their present environmental conditions. According to Lazarus and DeLongis (1983), a primary way of coping is to dispatch to the

periphery those items which are no longer useful and to invest in items more meaningful to the current situation. The elderly may perceive a lack of control over the events itemized in the Worry Scale and have simply made a realistic appraisal of their abilities to deal with those events. Beliefs about control influence the way one appraises stress as well as the way one copes.

In her work with patients undergoing surgery for problems, Cohen (1980) identified an avoidant/denial coping strategy which may be relevant to the elderly as well. Cohen found that people who restricted their knowledge or awareness of their medical conditions and the nature of their surgery and were unwilling to discuss it, did better in recovery than the "vigilant" patients. Although Cohen's patients were not elderly, her data support the value of avoidance as a coping method, especially in situations where a person is unable to exert control.

The Worry Scale itself appears to offer promise as an instrument useful in the assessment of the concerns of this population of elderly. It correlates well with other scales which purport to measure broader stress-related concerns. It is an efficient instrument, taking little time to complete, and is ready for immediate use in a therapeutic setting if necessary. The future-oriented character of the items may make it complementary to the past events perspective of the life events approach and the present time orientation of the Hassles Scale (Lazarus & DeLongis, 1983). Future investigations utilizing other independent assessments of psychological, physical, social, and financial well-being would contribute greatly to the evaluation of the Worry Scale as well as to the understanding of other people's perceptions of their situations in each of these areas.

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TABLE 1

Worry Scale with Response Distributions, Item Scores and Averages for Women and Men

THINGS THAT WORRY ME

	Never	Rarely	Sometimes	Often	Much of the time	Item Scores Total	Mean
Finances							
1. that I'll lose my home	84	8	1	1		13	.10
2. that I won't be able to pay for the necessities of life (such as food, medicine, clothing)	70	19	4			25	.20
3. that I won't be able to support myself independently	71	16	7			30	.24
4. that I won't be able to enjoy the "good things" in life (such as travel, recreation, entertainment)	59	19	11	5		56	.46
5. that I won't be able to help my children financially	60	13	5	3	2	50	.41
(Mean score for women = 6.92, S = 2.43; for men = 6.55, S = 1.85. Total mean = 6.74, S = 2.24)							
Health							
6. that my eyesight or hearing will get worse	39	30	16	6	3	92	.76
7. that I'll lose control of my bladder or kidneys	64	16	13		1	46	.38
8. that I won't be able to remember important things	46	24	14	8	2	84	.69
9. that I won't be able to get around by myself	48	27	11	4	3	73	.60
0. that I won't be able to enjoy my food	76	9	7	1	1	30	.24

	Never	Rarely	Sometimes	Often	Much of the time	Item Scores Total	Mean
11. that I'll have to be taken care of by my family	56	24	9	1		45	.37
12. that I'll have to be taken care of by strangers	61	19	8	2	4	57	.47
13. that I won't be able to take care of my spouse	43	9	2	1	2	24	.19
14. that I'll have to go to a nursing home or hospital	43	31	13	1	4	76	.62
15. that I won't be able to sleep at night	65	18	7	1		35	.28
16. that I may have a serious illness or accident	46	31	15	2		67	.55
17. that my spouse or a close family member may have a serious illness or accident	38	31	14	5	2	82	.67
18. that I won't be able to enjoy sex	67	13	2	1		20	.16
19. that my reflexes will slow down	50	32	8	1	1	55	.45
20. that I won't be able to make decisions	60	22	9	1	1	47	.38
21. that I won't be able to drive a car	53	25	5	2	1	45	.37
22. that I'll have to use a mechanical aid (such as a hearing aid, bi-focals, a cane)	57	20	5	3	1	43	.35

(Mean score for women = 26.97, S = 8.93; for men = 26.41, S = 8.52. Total mean = 26.82, S = 8.63)

	Never	Rarely	Sometimes	Often	Much of the time	Item Scores Total	Mean
Social Conditions							
13. that I'll look "old"	80	8	4			16	.13
14. that people will think me unattractive	76	10	3			16	.13
15. that no one will want to be around me	77	8	5	2		24	.19
16. that no one will love me anymore	76	8	7	1	1	29	.23
17. that I'll be a burden to my loved ones	49	28	11	3	2	67	.55
18 that I won't be able to visit my family and friends	61	22	5	3		41	.33
19. that I may be attacked by muggers or robbers on the streets	64	24	3	2		36	.29
20. that my home may be broken into and vandalized	44	32	10	3	3	73	.60
21. that no one will come to my aid if I need it	66	18	4	5		41	.33
22. that my friends and family won't visit me	80	7	4		1	19	.15
23. that my friends and family will die	50	26	10	5		61	.50
24. that I'll get depressed	63	16	9	4	1	50	.41
25. that I'll have serious psychological problems	71	14	2	4		30	.24

(Mean score for women = 18.8, S = 6.04; for men = 18.3, S = 6.58. Total mean = 18.6, S = 6.31)

Number of responses per question varies slightly because respondents did not answer all items, omitting particularly those regarding children or spouse which would not apply to all respondents.)

TABLE 2

Most and Least Frequently Expressed Items on the Worry Scale

Most Frequently Expressed Worries

	Item	Score
1.	that my eyesight or hearing will get worse	(92)
2.	that I won't be able to remember important things	(84)
3.	that my spouse or a close family member may have a serious illness or accident	(82)
4.	that I'll have to go to a nursing home or hospital	(76)
5.	that I won't be able to get around by myself	(73)
6.	that my home may be broken into or vandalized	(73)
7.	that I may have a serious illness or accident	(67)
8.	that I'll be a burden to my loved ones	(67)
9.	that my friends and family will die	(61)
10.	that I'll have to be taken care of by strangers	(57)

Worries Most Often Responded to in the "Never" Category

	Item	Score
1.	that I'll lose my home	(-84)
2.	that I'll look "old"	(-80)
3.	that my friends and family won't visit me	(-80)
4.	that no one will want to be around me	(-77)
5.	that people will think me unattractive	(-76)
6.	that no one will love me anymore	(-76)
7.	that I won't be able to enjoy my food	(-76)
8.	that I won't be able to support myself independently	(-71)
9.	that I'll have serious psychological problems	(-71)
10.	that I won't be able to pay for the necessities of life	(-71)

Table 3

Correlations for Worry Scores and MAACL and SCL-90 Scales

Worry	Total	Financial	Health	Social
SCL-anxiety	-.576 p=.001	-.320 p=.001	-.583 p=.001	-.484 p=.001
SCL-hostility	-.311 p=.002	-.078 p=.237	-.280 p=.005	-.349 p=.001
SCL-interpersonal sensitivity	-.552 p=.001	-.261 p=.008	-.512 p=.001	-.549 p=.001
MAACL-anxiety	.434 p=.001	.350 p=.001	.424 p=.001	.347 p=.001
MAACL-aggressive	.139 p=.100	-.081 p=.230	.150 p=.083	.164 p=.065
MAACL-vigor	-.257 p=.008	-.249 p=.010	-.235 p=.014	-.212 p=.024
MAACL-elation	-.204 p=.029	-.227 p=.018	-.165 p=.064	-.189 p=.040
MAACL-contentment	-.156 p=.074	-.103 p=.170	-.115 p=.143	-.186 p=.041